

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
SUTENT (sunitinib maleate)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext. and opt. _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY**

CRITERIA:

- ▶ Must be age 18 or above
- ▶ Documentation of advanced renal cell carcinoma
- ▶ Documentation of treatment history
- ▶ Documentation of disease progression on or intolerance to Gleevec

INFORMATION:

Dosing: 50mg daily, 4 weeks on and 2 weeks off. Dose increase or reduction is in 12.5mg increments.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter or progress note showing improvement or maintenance on Sutent.